twice a day. At each visit, the wound should be soaked in warm, soapy water before a clean dressing and some agent such as silver sulfadiazine (Silvadene) is applied. If any sign of cellulitis or gross infection appears, the patient should immediately be referred for definitive care.

THOMAS E. LITTLE, MD
West Coast Medical Director
Reynolds Metals Company
Longview Reduction Plant
Longview, Washington

REFERENCE

1. Kahn, MA, McCrady-Kahn VL: Molten metal burns (Information). West J Med 135:78-80, Jul 1981

The Halsted Mastectomy

TO THE EDITOR: I am disturbed by the article "The Halsted Mastectomy: Present Illness and Past History."[1] The aggressive feminist "macha" can of course write as she wishes—it is easy to brush aside the milieu of a century ago and to select those statements or opinions that best fit one's current literary endeavor. Rational thinking can be replaced by cuteness. Halsted was a leader of his time, and were he here today he would indeed be a leader. It is most unlikely that he would advocate the same surgery now as then. Rather, he would be thrilled and challenged by the new opportunities of the past two generations.

The only real complaint about the article is the wisdom of the editor in accepting it for publication.

GORDON T. BOWEN, MD
Lynwood, California

REFERENCE

1. Bland CS: The Halsted mastectomy: Present illness and past history (Special Article). West J Med 134:549-555, Jun 1981

* * *

TO THE EDITOR: The article "The Halsted Mastectomy: Present Illness and Past History" by Cordelia Shaw Bland was most entertaining. Although it is true that indications for a classical radical (Halsted) mastectomy are few at present, we take exception to most of her conclusions.

First, radical mastectomy was designed to remove the breast in continuity with its lymphatic drainage (including the transpectoralis lymphatic route), a principle of surgical oncology that had yielded higher cure rates in other organs, and not merely to separate surgeons from general practitioners as suggested by the author. It was accepted not because of economic or nationalistic reasons but because of the markedly lower incidence of local recurrence following this operation (Table 1).[1] While it is true that there is no correlation between survival and local recurrence, and in fact locally recurrent tumor is rarely the immediate cause of death among patients with breast cancer, this problem should not be underestimated. Ulcerated malodorous lesions of the chest wall are certainly a source of great distress to any patient with cancer and prevention of local recurrence is definitely one of the main goals of any treatment modality. When radical mastectomy was introduced, the average patient presented with advanced local disease and relatively extensive procedures were needed to achieve local control of the lesion. Fortunately this is no longer the case.

TABLE 1.—*Local Recurrence After Halsted's Radical Mastectomy Versus Recurrence After Lesser Procedures by Well-Known Surgeons of Late 19th Century**

Operator	*Time*	*No. of Cases*	*Local Recurrence (percent)*
Bergmann	1882-1887	114	51-60
Billroth	1867-1876	170	82
Czerny	1877-1886	102	62
Fischer	1871-1878	147	75
Gussenbauer	1878-1886	151	64
Konig	1875-1885	152	58-62
Kuster	1871-1885	228	59.6
Lucke	1881-1890	110	66
Volkmann	1874-1878	131	60
Halsted	1889-1894	50	6

*Adapted from Degenshein.[1]

Second, it is not true that radical mastectomy (or modified radical mastectomy) "rules out plastic surgery for a reconstructed breast," as a number of reconstruction modalities with good cosmetic results are available after these operations.[2,3]

Third, studies of the natural history of the disease suggest that carcinoma of the breast probably encompasses a heterogeneous group of diseases with variable time courses, but not necessarily that carcinoma of the breast is systemic in all patients from the beginning.[4] If the latter were true, and if local control were not important, then all screening programs for early detection would be a waste of time since early diagnosis and treatment would not influence the prognosis. This, of course, is not the case and even those who believe breast cancer is a systemic disease from the start advocate early treatment for patients with minimal breast lesions (positive mammograms, with negative physical examination of the breast and nodes).

Fourth, it is inaccurate to state that "limited excision (lumpectomy) followed by primary high-dosage irradiation is now considered the major alternative to radical mastectomy." Preliminary data suggest that segmental mastectomy plus

radiotherapy gives good results in patients with stage I,[5] but there is still controversy regarding the best treatment modality for breast cancer.

We believe that modified radical mastectomy is, at present, the procedure of choice for *most* patients with potentially curable carcinoma of the breast. This modality appears to cure the disease in patients in whom cancer is localized (about 20 percent of patients with breast cancer) and at the same time provides valuable staging information. The latter can be used to establish prognosis since the number of nodes involved is the single factor most predictive of 10-year and 20-year survival,[6] and most important the information obtained from the pathologic examination of the axillary lymph nodes is vital to ascertain the need for adjuvant therapy.

Finally, we believe it is unfair to imply or state that Halsted did not practice what he preached, that his operation was designed only to promote the economics of surgery, that he charged exhorbitant fees and that he avoided patients at all times. It is unjust to minimize his contributions in the field of asepsis, one of the greatest advances in surgery, pretending they represented only a romantic event. If it was important for the author to describe in detail Halsted's drug addiction and character problems it might also have been fair to point out that it was William S. Halsted's prodigious mind that laid the structure for the surgical residencies, the system used in training surgeons throughout the world today.

CARLOS PELLEGRINI, MD
Assistant Professory of Surgery
ORLO H. CLARK, MD
Associate Professor of Surgery
University of California, San Francisco
Surgical Service
Veterans Administration Medical Center
San Francisco

REFERENCES

1. Degenshein CA, Ceccarelli F: The history of breast cancer surgery. Breast 5:18-25, 1979
2. Lynch JB, Madden JJ Jr, Franklin JD: Breast reconstruction following mastectomy for cancer. Ann Surg 187:490-501, 1978
3. Dinner MI, Peters CR: Breast reconstruction following mastectomy. Surg Clin N Am 58:851-867, 1978
4. Henderson C, Canellos GP: Cancer of the breast—The past decade (Part 1 of 2 parts). N Engl J Med 302:17-30, 1980
5. Veronesi V, Saccozzi R, Del Vecchio M, et al: Comparing radical mastectomy with quadrantectomy, axillary dissection and radiotherapy in patients with small cancers of the breast. N Engl J Med 305:6-11, 1981
6. Fisher B, Slack NH: Number of involved nodes examined and the prognosis of breast carcinoma. Surg Gynecol Obstet 131: 79-88, 1970

* * *

TO THE EDITOR: I wish to commend you on your publication of Cordelia Shaw Bland's article on the Halsted mastectomy in your June issue. I felt a little ill inside when I read it.

It has always amazed me how much we physicians are influenced in how we practice medicine by those who often have so little direct contact with the kind of medicine *we* see on a daily basis. I can remember 25 years ago being told "pure gospel" by physicians who had never, and would never, be directly involved in the day-to-day caring for people.

As physicians, we are privileged to have the most intimate look at the best and worst of the human condition, and, if we seriously think or care at all about what we spend most of our time doing, I rather think our judgment will be quite good most of the time. But can we embark on what might turn out to be a better treatment when we are constrained by our attorney friends, and in fact our peers, to limit our treatments to the so-called community standard?

NORMAN C. HEADLEY, MD
Cameron Park, California

* * *

TO THE EDITOR: I look forward each month to THE WESTERN JOURNAL OF MEDICINE as a source of information regarding medical developments in the western states.

I write you now, however, to register a firm voice of displeasure regarding the publication of the article by Cordelia S. Bland in the June issue.

The article is filled with innuendo and extrapolation.

There is lack of logic, specious reasoning and repeated assumption that play no role in a medical journal. Reference to nonfactual material and to authors with an acknowledged bias is not appropriate.

Publishing the article represents an extremely poor editorial philosophy. The article falls well below the standard I expect from you.

SONNY P. COBBLE, MD
Los Angeles

* * *

TO THE EDITOR: Congratulations on the great article by Cordelia S. Bland. I thoroughly enjoyed it. It was written objectively and scientifically. THE WESTERN JOURNAL OF MEDICINE showed very good taste in accepting it. And, I congratulate the author on a job well done. Keep up the good work.

GEORGE CRILE, Jr, MD
Emeritus Consultant
Department of General Surgery
Cleveland Clinic
Cleveland

* * *

TO THE EDITOR: The article on the Halsted mastectomy in the June issue has proved a delight to